From: To: 2024429430 11/13/2008 04:03

DECAMINIEM LOF DEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G024 10/16/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW CMS WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) W 000 **INITIAL COMMENTS** W 000 On September 16, 2008 at approximately 5:00 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that Client #1 reported to Direct Care Aide #1 that she was struck in the face by Direct Care Staff # 2. GOVERNMENT OF THE DISTRICT OF COLUMBIA The SA conducted an on-site investigation on October 15-16, 2008, to verify compliance with DEPARTMENT OF HEALTH the basic standards of practice and federal HEALTH REGULATION ADMINISTRATION participation requirements in the Conditions of 825 NORTH CAPITOL ST., N.E., 2ND FLOOR Governing Body and Client Protection. The WASHINGTON, D.C. 20002 investigation determined that Direct Care Staff # 2 was placed on administrative leave on September 16, 2008. The facility's internal investigation did not substantiate the allegation of abuse and Direct Care Aide # 2 was returned to duty on October 7, 2008. It should be noted however, that Direct Care Aide # 2 was scheduled to work at another ICF/MR facility operated by the provider. The results of the investigation were based on interviews with Client #1, Direct Care Aides, nursing and administrative staff. Additionally, the findings were based on the review of the client's medical record and the facility's administrative records; including incident reports. A monitoring survey was also conducted on October 15-16, 2008, to determine the facility's continued compliance with the deficiencies cited during the recertification survey on March 6, 2008. The findings of the survey were based on interview and record review, including incident reports. At the time of this monitoring visit standard level deficiencies were cited. W 156 483.420(d)(4) STAFF TREATMENT OF W 156 ORY DIRECTOR'S OR PROVIDE OSUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that following the date of survey whether or not a plan of correction is provided. For nursing homes, the findings stated above are disclosable 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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UEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G024 10/16/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW CMS WASHINGTON, DC 20011 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 156 Continued From page 1 W 156 **CLIENTS** The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident. The finding includes: Review of the internal investigative report on In the future, all results of the October 16, 2008, at approximately 2:35 PM investigation will be reported to revealed that Client #1 stated that the incident the administrator within 5 working occurred on September 15, 2008; however Client days. QMRP and Residential Manager #1 did not report the incident to Direct Care Aide #1 until September 16, 2008. The internal will submit required documents investigation was completed on September 23, including statements from staff 2008. There was no evidence the result of the individuals involved, and the investigation was reported to the administrator results of the investigation withwithin five working days of the incident. in 5 working days. W 193 483.430(e)(3) STAFF TRAINING PROGRAM 11/7/08 W 193 Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on staff interviews and record verification, the facility staff failed to demonstrate competency in implementation the Behavior Support Plan (BSP) for one of one client being investigated.

DEPAI CENTI	RTMENT OF HEALTHERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024			(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED		
			B. WING		104	6/2008		
NAME OF	PROVIDER OR SUPPLIER		S [*]	TREET ADDRESS, CITY, STATE, ZIP (10/2008		
CMS				703 RANDOLPH STREET NW WASHINGTON, DC 20011				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
W 193		ge 2	W 19:	3	·			
• :	(Client #1)				•			
	The finding includes	s :	-					
	Dovious of the facility	· · · · · · · · · · · · · · · · · · ·		,				
	October 15, 2008 at	y's unusual incident reports on approximately 9:00 AM			·			
	revealed a report da	ited September 16, 2008.						
•	I he report revealed Direct Care Aide (D)	that Client #1 reported to CA) #1 that she was struck in		·				
	the face by Direct C	are Aide # 2.						
•	Intension with DCA	#4 on O-4-b 45, 0000 -+			٠	•		
	approximately 3:00 i	#1 on October 15, 2008 at PM revealed that on	,	,	•			
•	September 15, 2008	at approximately 8:00 PM.			-			
•	she overheard a loud	d verbal altercation coming or bathroom. Further interview		,				
	revealed that when [DCA #1 opened the bathroom						
	door, she observed t	that Client #1 was screaming			*-	-		
	with a washcloth in a	s covering Client #1's mouth in attempt to stop Client #1						
	from screaming.	an attempt to stop official #1		· · · · · ·		1		
	Interview with DCA #	2 on October 15, 2008 at			.*	.		
	approximately 7:20 F	PM revealed that on						
	September 15, 2008	at approximately 8:00 PM,						
	when Client #1 begain	g Client #1 to take a shower n to scream continuously and						
	shout at DCA #2 "I de	on't like you: do I have to						
,	take a shower? "Fu	rther interview revealed that to stop Client #1 from						
1	screaming. In additio	n, when DCA #1 opened the				Ì		
	bathroom door DCA; a washcloth to cleans	#2 stated that she was using				,		
-	Review of Client #1's	Behavioral Support Plan				·		
	(BSP) dated January	21, 2008 on October 16.	•					
	2008 at approximately behaviors that include	y 2:00 PM revealed targeted ed physical aggression,			٠.			
	accusing, non-compl	liance, feces related						

To: 2024429430

11/13/2008 04:04

#957 P. 005/009

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO 0938-0391

STATEMEN	IT OF DEFICIENCIES	WAY BROKE OF THE	/IOEG	7.7			OMB NO	<u>. 0938-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			ETED			
		09G024		B. WIN	iG_		10/1	6/2008	
NAME OF I	PROVIDER OR SUPPLIER			<u> </u>	STD	REET ADDRESS, CITY, STATE, ZIP CODI		0/2006	
CMS					70	703 RANDOLPH STREET NW	_		
			·· <u> </u>	·	·W	WASHINGTON, DC 20011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	(X5) COMPLETION DATE		
W 193	Continued From page	ge 3	i	W 1	93				
	behaviors, self-injur		.[•••	~			•	
•	stealing/hoarding, F	urther review reveal	ed that			All staff were trained	by the	,	
	interventions for the	first sign of agitation	included			facilities Behavioral	Specialis	¢	
	re-directing the clie	nt to something spe	cific. such			on Individual #1's Beh			
-	as to stand calmly w	ith her hands at her	sides, or			Support Plan. The QMRP	and Res-		
	to sit in a specific ch	air, or to take ten de	ер			idential Manager will	monitor		
	breaths." There was	s no evidence that o	n ·			implementation of Indi	vidual #1	s.	
	September 15, 2008	, the facility staff			ĺ	Behavior Support Plan.		11/7/08	
	demonstrated comp of the client's BSP.	etency in the implen	nentation					,,	
	of the chefft's BOF.		. 1	-					
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To: 2024429430

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE HFD03-0085		ER/CLIA IMBER:	(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
			10/16/200						
C M S 703 RAND				DDRESS, CITY, STATE, ZIP CODE DOLPH STREET NW GTON, DC 20011					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC (DENTIFYING INFORMA	FILL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLE DATE			
1 000	INITIAL COMMEN	rs	11	1 000					
	PM the State Agentacsimile of an Unutrom the facility that reported to Direct C	2008 at approximate cy (SA) was notified was notified was notified to sual Incident Report t revealed that Reside are Aide #1 that she y Direct Care Staff #	via (UIR) ent#1 was						
	The SA conducted October 15-16, 200 the basic standards participation require Governing Body and investigation determ 2 was placed on ad September 16, 200 investigation did not abuse and Direct Caduty on October 7, 2 however, that Direct	an on-site investigation 8, to verify compliance of practice and fede ements in the Condition of Resident Protection ined that Direct Careministrative leave on 8. The facility's interret substantiate the alleare Aide # 2 was returned to the care Aide # 2 was at another ICF/MR facility and the facility in the care Aide # 2 was at another ICF/MR facility and the care Aide # 2 was at another ICF/MR facility in the care Aide # 2 was at another ICF/MR facility in the care Aide # 2 was at another ICF/MR facility in the care Aide # 2 was at another ICF/MR facility in the care Aide # 2 was at another ICF/MR facility in the care Aide # 2 was at another ICF/MR facility in the care Aide # 2 was at another ICF/MR facility in the care in the	on on ce with ral ons of n. The e Staff # nal egation of urned to						
1 	interviews with Resinursing and adminis Findings were based	vestigation were bas dent #1, Direct Care strative staff. Addition on the review of the the facility's administ cident reports.	Aides, nally, the client's						
0 2 iii	October 15-16, 2008 continued compliand during the recertifica 2008. The findings on terview and record	was also conducted b, to determine the fa ce with the deficienciention survey on March of the survey were bat review, including inco of this monitoring visencies were cited.	ecility's es cited o 6, sed on						
Ith Regulation	on Administration The provide provide the provide the provide the provide the provided the prov	RISUPALIER REPRESENT.	ATIVE'S SIGNA	ATURE	P TITLE A		X6) DATE		

FORM APPROVED

_Health I	Regulation Administra	ation			FOR	M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD B. WING	INGCOMP	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET AD						/16/2008
CMS 703 RAND				DOLPH ST GTON, DC	REET NW	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 090	Continued From page	ge 1		1 090		
1 090	3504.1 HOUSEKEE	PING		1090		
	maintained in a safe and sanitary manner	erior of each GHMRI e, clean, orderly, attra r and be free of t, rubbish, and objec	active,	·		
	odors.					
	Based on observation	net as evidenced by: ons, the GHMRP faile n,orderly, attractive f obish	edto İ			
	The findings include:	:		•		
1	During the environmon October 15, 2008 the GHMRP failed to	ental inspection cond at approximately 1:3 ensure the following	30 PM			
	Internal				Internal	
3	1. A hole was observ #2 exposing rotting w	red in the ceiling of b vood and water dama	athroom age.		1. The hole in ceiling of the bathroom will be repaired.	11/14/08
1	2. The kitchen ceiling near the pipes.	j had some water da	mage		2. The Fitchen ceiling will be repaired.	11/14/08
	3. A large hole was o furnace room.	bserved in the wall o	of the		3. The hole in the wall of the furnace room will be repaired.	11/14/08
[External				External	
€	The ceiling near the exposed screws hang	ging from the wood o	d eanel		 The ceiling near the backdoor exit will be repaired. 	11/14/08
(covering the sheet root. Excessive bird drop	ck.			2. The backdoor exit near the stairs will be cleaned.	11/14/08
_ 0	loor exit stairs.			· '	·	
anın regulatı	on Administration					

11/13/2008 04:05

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PRINTED: 11/03/2008 FORM APPROVED

<u>Health</u>	Regulation Administra	ation						FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			СОМРІ	(X3) DATE SURVEY COMPLETED			
NAME OF	PROVIDER OR SUPPLIER	HFD03-0085	STREET AD	DDEOR OTH				10/	16/2008
	NO NO LIK OK SOFF LIER			DRESS, CITY		CODE		,	
CMS			WASHING	OOLPH STE STON, DC :	REET NW 20011	-1 - 1.			1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(E	PROVIDER'S P ACH CORRECT SS-REFERENC DEI	IVE ACTION S	SHOULD BE	(X5) COMPLETE DATE	
1 422	Tompa	-		l 422		-			
l 422	3521.3 HABILITATI	ON AND TRAINING		I 422	Cross	referenc	e W193		11/7/08
	and assistance to re	provide habilitation, t esidents in accordance idual Habilitation Pla	e with					. ·	
	Based on staff inter the facility staff faile in implementation th	met as evidenced by: views and record veri d to demonstrate con e Behavior Support I e Resident being inve	fication, npetency Plan					÷	
	The finding includes	:	-						
	October 15, 2008 at revealed a report da	that Resident #1 repo CA) #1 that she was s	AM 008 orted to						
	Interview with DCA # approximately 3:00 F September 15, 2008 she overheard a loud from the second floo revealed that when E door, she observed the screaming and that E	M revealed that on at approximately 8:0 I verbal altercation or bathroom. Further in DCA #1 opened the bhat Resident #1 was DCA #2 was covering	0 PM, oming nterview athroom						
	Resident #1's mouth attempt to stop Resid	lent #1 from screami	ng.			·			
	Interview with DCA # approximately 7:20 P September 15, 2008 DCA #2 was assisting shower when Reside continuously and sho you; do I have to take tion Administration	M revealed that on at approximately 8:00 g Resident #1 to take nt #1 began to screa ut at DCA #2 "I don't	0 PM, e a m like						

FORM APPROVED

Health i	Regulation Administra	ation				FORM	I APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED			
NAME OF E	PROVIDER OR SUPPLIER	HFD03-0085	CTDEET AD			10/16/2008		
CMS	— · · · ·		703 RANI	DOLPH STE STON, DG 2	, STATE, ZIP CODE REET NW 20011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
l 422	Continued From page	ge 3		1 422		-		
	stop Resident #1 from when DCA #1 open	hat DCA #2 was una om screaming. In add ed the bathroom doo using a washcloth to	dition, or DCA #2					
	(BSP) dated Januar 2008 at approximate behaviors that include	urther review revealed first sign of agitation sident to something something something something something and the control of the second states and evidence to the facility staff.	er 16, I targeted sion, d ed that included specific, at her ke ten hat on					
						,		
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		·						
alth Regulat	ion Administration	· · · · · · · · · · · · · · · · · · ·						